Volume II, No. 4

Quality Views

A Publication of HCA Behavioral Health Services, Quality Improvement & Program Compliance

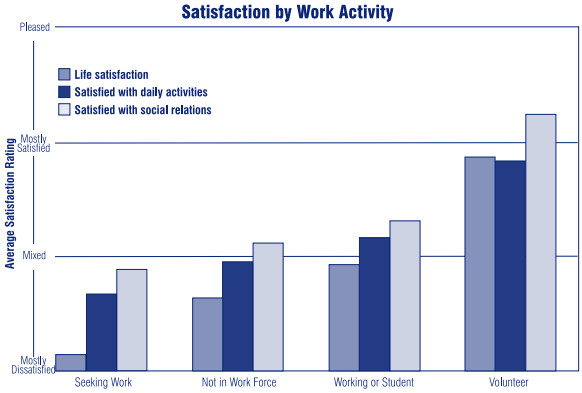
INSIDE THIS ISSUE

Work Situation and Life Satisfaction—Applying Research to Practice

Jonathan Rich, Ph.D.

Clients receiving mental health services from County agencies are routinely administered Performance Outcome measures. These measures serve a number of purposes. They allow the County to be accountable to the State, and to demonstrate that our services are helping clients to improve their lives. They allow clinicians to track the progress of individual clients. Analysis of aggregate data can provide helpful information about how to best help our clients.

Clinics in Adult Mental Health Services collect information about clients' current employment situation. Also, the Quality of Life scale is administered to assess clients' satisfaction with various aspects of their lives. I looked at the relationship between life satisfaction and job situation for the 3,716 records currently in the Adult Performance Outcome file. This relationship can be seen in the figure below:



The least satisfied individuals indicated that they were "Seeking Work." One can easily imagine that the financial pressures of unemployment, the lack of structured daily activities, and the rejection associated with applying for work make this an unpleasant circumstance, particularly for persons with psychiatric impairments. The clients who were seeking work indicated that they were "Mostly Dissatisfied" to "Mixed" in their feelings about their overall life situation, their daily activities, and their social relationships. Slightly greater satisfaction was seen among people who were not in the work force. This included clients who identified themselves as homemakers, inmates, retired, or who were otherwise not involved in work outside the home. The "Working or Student" group included people who were students, or were working full or part time in supported or competitive employment. These individuals expressed satisfaction near the "Mixed" level. The most satisfied group was volunteers. They typically expressed satisfaction close to the "Mostly Satisfied" level. This makes sense, since volunteer work provides structure and a

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Helping unemployed clients to find work can have a positive impact on their feelings of satisfaction.

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Quality Improvement Workplan update

Daniel Ketchum, RPh

At the end of each Fiscal Year, Behavioral Health Services is required to send to the Department of Mental Health (DMH) a review of the past year's activities and accomplishments, and a plan for the new year. Not only does this inform DMH about quality-related work completed, but it requires that we plan our future activities and document these plans in writing. This planning is accomplished by a number of workgroups and interdepartmental discussions, and forces these groups to ask questions like:

- Are we seeing any 'warning' trends?
- In what direction is the State Dept. of Mental Health going, in terms of quality?
- What feedback are we receiving from our clients and the community?
- Do we have any benchmarks available to us to allow comparison with another organization?

These draft ideas are circulated among managers and staff to help us prioritize them. Planning helps us balance needs and resources (funds, staffing, etc); helps us ensure activities are achievable and measurable; and helps us involve all Divisions and departments. The Quality Improvement and Program Compliance (QIPC) Department is responsible for coordinating quality-related activities, assisting Division staff with quality improvement activities, and providing periodic reports to DMH.

Summary of the 2000-2001 Annual Review

Of the seventy quality-related activities/tasks established in last year's Workplan, 68 were partially or completely accomplished. Many of these 70 items were carried over into this year's Workplan. The fact that 68 items were "completed" doesn't necessarily mean that the results were all we had hoped for, it just means that we collected the data as planned. In one example, sampling of data showed that 79% of clients received an initial appointment within 5 days of initial contact. We collected data, but hope we can improve the results. The focus of DMH and the healthcare sector in general is to spend more time on analyzing data, implementing possible improvement actions, and re-measuring data as a follow-up.

Other highlights include the implementation of the Adult Performance Outcome Measurement System; completion of a survey conducted by Cultural Competency; the opening of several new clinics in response to the community; and a more comprehensive analysis of medication-use data in the Prescribing Guidelines Committee.

Summary of the 2001-2002 Plan

This year's Workplan improves on an already solid plan from last year, with greater focus on communication of results to staff and to the Community Quality Improvement Committee, and on more systematic collection of data in a broader number of areas. The following are a few selected activities of the Workplan:

Inpatient Services

Behavioral Health Services plans to collect information on three issues pertaining to acute hospitalization: time from initial post-hospitalization to subsequent face-to-face visit; number of face-to-face visits in the first 60 days post-discharge; and our re-hospitalization rate.

Transition of care

An issue identified during 1999-2000 was that clients were not notified in a timely manner of changes to their treatment team (psychiatrist, care coordinator). A brief review was begun last year, and the project will continue this year.

Access to services

QIPC will work closely with Division Quality Review and Training (QRT) staff to gather more information regarding client access to their first outpatient appointment. Information on the response time of our Administrative Services Organization (ASO) to callers will be collected, as will data regarding physical health emergencies referred from ETS.

Client satisfaction

Clients who are hospitalized will continue to be surveyed following discharge. Cultural Competency will work together with QIPC to analyze surveys conducted. QIPC will continue to help gather information on client grievances and requests for change of provider/2nd opinion. Grievances and complaints are ways that clients and their families tell us of their concerns or dissatisfaction.

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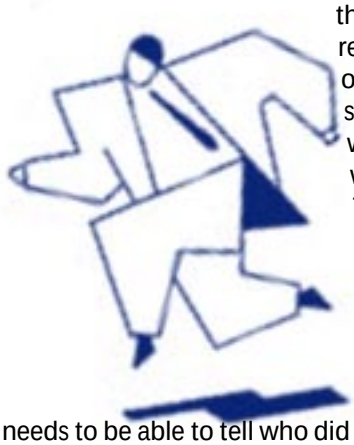
Have you thought about your Therapist Number lately?

David Horner, PhD

When you begin working as a therapist/counselor/etc. for BHS, one of the first things that happens is that an application is submitted to our IT department for the assignment of a therapist number. This number is the one that you put on the encounter documents. It is entered into the MIS system and is what identifies who performed the service. So, what is there to think about?

Well, as you may remember from recent coding and documentation training or from recent compliance program training, it is an expectation that all BHS staff will accurately represent all services provided. That means that we will accurately represent the number of minutes a client was seen, what was done with the client, and who saw the client. This not only makes good sense from a compliance perspective, it makes good clinical sense. Someone picking up the medical record needs to be able to tell who did what with a client in order to insure continuity of care.



In addition to accurately reflecting this in the medical record, we have to accurately reflect this in the MIS system. After all, in many cases, the billing for services is done directly from MIS, so if the data we put into MIS isn't correct, the billing may not be correct.

What this means is that your therapist number reflects you as a service provider. If you performed a service, then it is your therapist number that should be turned in along with that service. If you did not perform a service, then your therapist number should not be linked to that service.

So, what do you do if you think that someone is using your therapist number, if you notice someone not using a therapist number correctly, or if someone tells you to use someone else's therapist number? Check it out. As you learned in the recent Compliance Program training, the first step is to try to work it out with the people involved. If that doesn't work, you have the options of going through your Service Chief and chain-of-command, the Compliance Office, or the Compliance Hotline [(866)-260-5636].

Work Situation and Life Satisfaction

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sense of purpose without the stresses and performance expectations inherent in paid work.

These results suggest at least two interventions that might increase clients' satisfaction with their lives. Helping unemployed clients to find work can have a positive impact on their feelings of satisfaction. Secondly, for clients without pressing financial needs and without structured day activities, encouraging volunteer work may be quite beneficial.

Of course, it is important to be cautious when making causal inferences from research, particularly when data is gathered without the benefit of a formal experimental design. For instance, it could be that volunteer activity does not increase satisfaction, but that clients who are already satisfied with their lives are more likely to seek out volunteer work. Ultimately, decisions about how to best help your clients will come down to your clinical intuition and your personal understanding of each client's unique potential. By combining our talents as therapists with data based knowledge, we can continue to provide the highest quality services to our clients.

Dr. Rich, Ph.D. is a psychologist at Quality Improvement and Program Compliance. He has taught statistics and research design at CSU, Fullerton and other universities. Past employment included work as a psychologist at a Texas State prison and at County of Orange Alcohol and Drug Abuse Services. In addition to his County work, he maintains a private practice with specialties in psychological testing and research design and analysis.

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BHS Quality Improvement Committee (QIC) Update

Dan Ketchum, RPh

Over the past year, Children and Youth Services (CYS) Division and Adult Mental Health Services' Westminster TRC (WTRC) have worked with Quality Improvement/ Program Compliance (QIPC) staff to redesigned their QIC process in order to improve how services are delivered.

Children and Youth Services

Beginning mid-2000, several members of CYS (Margi Brothers, Aida Sanchez-Nunez) and QIPC (Dan Ketchum, Cort Curtis, Jon Rich) met several times to discuss how CYS could add new features to its existing structure:

- Ensure that a psychiatrist could attend each QIC meeting
- Improve communication between approximately 44 clinics and central administration
- Use statistical analysis of data, when appropriate
- Capture information about "systems issues"
- Encourage managers and clinic staff to jointly discuss quality issues, and to develop action plans for further review and follow up

Feedback was obtained from administrative and clinical staff, and a new Committee was established- the Divisional QIC Committee. The quarterly clinic-based QIC meetings were retained in order to allow staff to discuss cases and service-delivery problems. CYS and QIPC staff met with each clinic and staff over a period of several months to discuss the proposed ideas and invited further input. Each clinic was encouraged to meet quarterly to discuss high-utilizing or problematic cases. The QIC meeting form was re-designed as a "meeting minutes" to allow clinic staff to document their meetings and any findings or recommendations.

The completed forms are sent to Division QRT staff who review each one for data collection and potential issues for discussion at the Division QIC meeting. The new Divisional QIC Committee was designed to include representation by County and Contract providers; clinicians; managers; and QRT staff including CYS' QRT Psychiatrist.

The Divisional QIC Committee has met several times since last year, and has been very well attended. Meetings use an agenda, which includes:

- Old business
- Analysis of quarterly data
- Clinical Care Issues
- Consumer Related Issues
- Organizational Issues.

This has helped the Committee members review a wide range of topics including: Treatment of Substance Abuse; Performance Outcome System procedures; and Treating Children with Sexually Acting Out Behaviors.

WTRC

Over the past year, staff from WTRC (led by Janice Ervin) and QIPC (Dan Ketchum) met to discuss WTRC's existing quality improvement procedures. Staff at WTRC had been conducting several meetings (e.g. Quality Improvement, Utilization Review, Chart Audit), some monthly and some quarterly, but believed the quality improvement process could be streamlined. Also, staff wanted to develop new indicators and projects to measure and improve its program. State regulations were reviewed (since WTRC is part of a Skilled Nursing Facility), as were existing policies and old meeting minutes. A new model was proposed which redesigned their Quality Improvement Committee to allow for better data collection and analysis, as well as communication with staff. WTRC staff attended an inservice in mid-August to familiarize themselves with the latest quality-improvement concepts and methods.

The new QIC Committee met for the first time in mid-September, and was able to decide on several new projects and indicators. This new Committee plans to meet quarterly beginning in October.

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New medicines under development

Dan Ketchum, RPh

Thousands of new medications are currently being researched for possible use to treat a wide range of illnesses, from Alzheimer's to Arthritis and from Diabetes to Depression. According to the Pharmaceutical Research and Manufacturers' Association, it takes 12-15 years on average for an experimental compound to travel from the lab to U.S. patients. Only five in 5,000 compounds that enter preclinical testing make it to human testing. Just one of these five tested in people is approved[1].

Drug Development and Approval Process

Potential new drugs must pass a lengthy and expensive review process in order to ensure that, once marketed, the drug is safe and effective.

In the ***pre-clinical testing phase***, companies conduct lab and animal studies to measure the biological activity of a compound. This phase generally takes 6-7 years. Once a potential new compound is identified, the company may file an Investigational New Drug Application (IND) with the Food and Drug Administration (FDA).

Once an IND has been approved by the FDA, the pharmaceutical company may begin limited human studies, often involving 20-80 normal, healthy adults. This phase, called **Phase I**, evaluates a drug's safety profile, dosage range, and pharmacokinetic (blood level measurements) profile. This phase may take 1-2 years.

Once a drug has cleared Phase I, it is moved into **Phase II** in which generally 100 patients with the target illness are included in study groups to test the drug's effectiveness.

In **Phase III**, several thousand patients are included in rigorous clinical studies at numerous academic medical centers, physician offices, and research organizations to confirm effectiveness and safety. Phases II and III may each take several years to complete.

If a drug completes Phase III, the company may file a ***New Drug Application (NDA)***, and submit all study data, to the FDA for review. Once the drug is approved, the company may market the drug, but it must continue to submit post-market reports to the FDA.

New Medicines for Mental Illnesses

According to PhRMA, 103 compounds are being evaluated for treating various mental illnesses in all age groups:

Illness	Approx. # drugs under development according to PhRMA	Approx. # drugs under development according to Biospace.com	Examples of drugs under development
Addiction	21	23	Tempium, Campral
Anxiety	13	69	Flesinoxan, pagodone
ADHD	10	19	Aricept, Inversine, Perceptin
Dementias	24	17	Acetyl-canitine, talsaclidine
Depression	26	69	Duloxetine, gepirone
Eating Disorders	5		Axokine, leptin, ecopipam
Panic Disorders		9	
PTSD	2		
Pre-menstrual Disorders	3		
Schizophrenia	16	25	Aripirazole, amisulpride
Sexual Disorders	3		Apomorphine

[1] PhRMA.org

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Quick Reference Guides

Daniel Ketchum, RPh

Many of us have probably participated in developing a new form, brochure or document for use with client services or in some aspect of clinic/site operations. Forms and documents used in delivering client services are generally filed in the client chart. These documents must adhere to numerous local, State and Federal requirements such as required language/phrasing, signature requirements, and copyright laws. The Agency also expects that documents in client charts are consistent whenever possible. Brochures, handouts and other print materials that are used in describing our services and programs present an image of HCA- one we want to maintain in the highest quality.

The HCA Forms Committee and the Public Information and Communications Office have each developed a reference guide to help all HCA staff in developing forms and documents. The Public Information and Communications Office guide is titled "Print Materials" and is available by calling 714-834-2178. The Forms Committee guide is titled "Quick Reference Guide to Forms and Documents" and can be requested using form # F042-01.1959 (rev7/01). Both of these references should be reviewed before developing any new form, brochure, handbook, or other printed document.

Quality Improvement Committee update

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Quality Improvement Committee (QIC) activities

Although each Division conducts QIC meetings slightly differently, their goals are consistent- collect information about high-risk and high utilizer clients as well as look at "system issues" to try to uncover underlying problems with delivering services. Better ways to inform the Community Quality Improvement Committee of significant trends, data and issues will be explored.

New medicines

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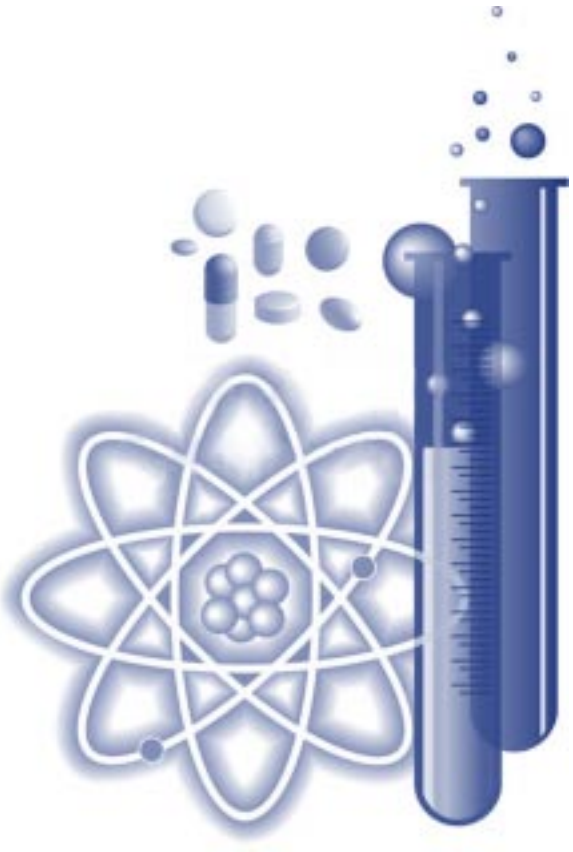
New Medicines for Older Adults

Several hundred drugs are being researched for use in *older adults*, for conditions such as Alzheimer's, Bladder/Kidney Disorders, Depression, Eye Disorders, Gastrointestinal Disorders, and Parkinson's Disease.

Of the approximately 26 compounds being tested by 16 companies for use in depression in order adults, many are in Phase II and III clinical trials. One example is duloxetine, which was recently reported to have a high symptom remission rate and possesses significantly greater improvement in depressive symptoms when compared to SSRIs. Another source of drug development information, Biospace, reports over 65 drugs under development for depression.

Sources: www.PhRMA.org and www.biospace.com



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New Encounter Document

Jeffrey Nottke

The first revision of the Encounter Document has been released and is effective immediately. Changes were made to accommodate more service/CPT codes utilized by some programs. There was also a change made in the financial section. The 'circled' financial information at the top left side of the new Encounter Document now needs only to be simply Medicare, Medi-Cal, Private Insurance or None. This is because our Central Billing Department is utilizing the client face sheet printout as the billing authority of the client's beneficiary status, so the level of detail and payable order is no longer required. If a person has Medicare, just circle Medicare. If a person is Medi-Medi, just circle Medicare and Medi-Cal, etc.

Pink copies should now be utilized for only two scenarios: 1) ***any*** client with private insurance, regardless of the treating clinician, and 2) clients who are Medicare beneficiaries and are being treated by a PPIN eligible clinician [M.D., Ph.D., LCSW]. All other encounters should be done on a white ED (including clients with Medicare who are being treated by a non-eligible PPIN clinician).

One of our requirements is for the Medical Coder to review 100% of billable Medicare ED's, and 20% of non-billable ED's. Therefore, office staff have been instructed to keep a log of all Medicare clients who are receiving services, and the client needs to be logged each time they receive a service. This is mainly for the Medical Coder to identify clients seen by non-eligible PPIN clinicians so that she can do her 20% review (she doesn't see the white ED's, so a system to track that for us had to be put in place).

2001 Directory of Patient Assistance Programs now available

Dan Ketchum, RPh

The research-based pharmaceutical industry has had a long-standing tradition of providing prescription medicines free of charge to physicians whose patients might not otherwise have access to necessary medicines.

To make it easier for physicians to identify the growing number of programs available for needy patients, member companies of the Pharmaceutical Research and Manufacturers of America (PhRMA) created this directory. It lists company programs that provide drugs to physicians whose patients could not otherwise afford them. The programs are listed alphabetically by company. Under the entry for each program is information about how to make a request for assistance, what prescription medicines are covered, and basic eligibility criteria. You may find this Directory useful if you are aware of a client with physical health problems and is not able to afford medication necessary to control or manage his or her illness. The Directory may also be useful if a client must continue mental-health medication they are already receiving from a pharmaceutical company.

To download this Directory, go to www.PhRMA.org and double-click on "2001-2002 Directory of Patient Assistance Programs". Scroll down to the icon and double-click to open the file. You will need Adobe Acrobat to read the document. You may print the document once you've opened it.

For additional copies of this directory, please call (800) 762-4636.

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Quality Views

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If you would like to contribute an article, have some comments on the content, have ideas or other suggestions on how we can improve the newsletter, please contact us at:

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